MANAGEMENT RESPONSES

1. GROUP INSURANCE RESERVE

RECOMMENDATION 1

Finance should adopt a formal fund balance reserve for the Group Insurance Fund.

Management Plan of Action:

Finance will have a resolution establishing a minimal CHIP ISF fund balance.

Timetable: December 2003

RECOMMENDATION 2

Insurance Services should annually hire an independent certified actuary to a.) establish employer and employee health insurance premiums adequate to cover medical costs, and b.) determine an appropriate fund balance reserve for the Group Insurance Fund and a premium component for building the recommended reserve.

Management Plan of Action:

a.) An independent actuary was hired in 2002 to assist in establishing premium equivalent rates for the plan year beginning 2003. It is the intent of the Insurance Committee to continue to engage an independent actuary for each upcoming plan year.
b.) If the Finance Department determines that a Group Insurance Fund reserve should be established, the actuary engaged to assist in establishing premium equivalent rates will also be requested to provide a rate necessary to establish such a reserve.

Timetable: Completed in 2002

2. CONTRACT REQUIREMENTS

RECOMMENDATION 1

Insurance Services should complete an analysis of insurance costs paid on behalf of dependents to determine whether the City is in compliance with the contract.

RECOMMENDATION 2

Insurance Services should ensure that the actuary considers the contract requirements when determining insurance premiums.

RECOMMENDATION 3

Insurance Services should adjust the verbiage as needed and modify the contract to reflect the actual method of determining insurance premiums.

Management Plan of Action:

The wording of the labor agreement was originally formulated when the City was fully insured and purchased insurance with specific, set premiums. Rates were set in advance of the plan year and remained the same, regardless of the actual payments made by the insurance company on behalf of the plan members.

In July of 1998 the City became self-insured for its group health, and no longer purchases insurance coverage. As a self-insured entity, the City pays medical, dental, and vision claims as they occur. Therefore, the cost of the plan fluctuates, based on the utilization of services by the members. To establish a premium equivalent rate that is adequate to cover the expected costs of the plan, an actuary is provided with information on the expenditures and trends of the previous years. The actuary then extrapolates a recommended rate, utilizing the City's loss experience and information he has on such things as expected changes in costs of health care, regional differences in costs, and other factors expected to affect the overall cost of the plan. The Insurance Committee is provided with the recommended premium equivalent rate and they establish the rate to be charged for the upcoming year.

While every effort is made to establish a premium that reflects the actual cost of the plan as accurately as possible, the nature of self-insurance does not allow for the exact payment of "50% of the dependent insurance coverage costs. The only methodology that would enable the City to do so would be a retrospective program, where all dependent costs were calculated after the fact and then the employees were either billed for additional monies owed to the City, or provided with refunds. This would be extremely unwieldy from an accounting standpoint and undoubtedly very unpopular with the employees.

Insurance Services has no authority or ability to change contractual language. However, the Human Resources Director has indicated management will be seeking a Memorandum of

Understanding with the City Employees Association that reflects the actual methodology used in the calculation and payment of premium equivalents for the group insurance plan.

Timetable: This is anticipated to be accomplished at the completion of contract negotiations.

3. INSURANCE PLAN COMPONENTS

RECOMMENDATION 1

Insurance Services should evaluate alternatives to the current health plan such as consumer driven health care and HPN (an HMO – Health Maintenance Organization), which will continue to provide quality health care to employees and significantly reduce the City's financial exposure.

Management Plan of Action:

Insurance Services is currently working with our health care consultants from Marsh, USA to develop a plan for consumer driven health care that, if approved by the Insurance Committee and the City Council, would be offered as an alternative to our employees for the 2004 plan year.

HPN has been offered as an alternative to our employees since 2001. Currently, only 84 employees are enrolled. Due to the limitations in coverage and choice inherent in an HMO, our employees have primarily elected to remain with CHIP. Offering an HMO as the only option available would result in a lower cost to the City. However, again, due to the limited nature of the coverage, neither the City Council nor the Insurance Committee has recommended such a change. If they were to do so, Insurance Services would act in accordance with their wishes. The following is our estimated timetable on investigation and possible implementation of a consumer driven health plan alternative offering:

Timetable:

Review of feasibility of CDH	May 30, 2003
Development of CDH proposal completed:	July 1, 2003
Presentation to Insurance Committee	July 15, 2003
Presentation to City Council (if recommended by Insurance Committee)	Aug. 1, 2003
If Approved by Council:	
Educational meetings & communication	Aug. through September
Open Enrollment	Oct. & Nov., 2003

RECOMMENDATION 2

Insurance Services should consider, evaluate and document options which provide employees incentives to live healthier lifestyles (non-smokers, going to a gym) and limit usage of medical services.

Management Plan of Action:

Insurance Services has negotiated reduced rates for our employees with both 24 Hour Fitness and Las Vegas Athletic Club, and regularly advertises these arrangements. Smoking

cessation classes have been regularly scheduled and unfortunately, poorly attended. Often, employers provide incentives in the form of reduced premiums to encourage healthy lifestyles. However, since the City employees do not pay for their insurance coverage, it is difficult to improve on "free".

Over the life of the self-insured plan numerous changes have been made in an effort to contain costs. The prescription drug plan has been changed dramatically to encourage generic drug usage and ensure that employees pay an appropriate share of the cost of the more expensive brand name drugs. Co-pays, out-of-plan deductibles and total out-of-pocket costs have been increased. In 2002, the rates for active employees and retirees, that had been previously blended, were separated, so that the retirees' rates were more reflective of their actual costs to the plan.

Prior to the inception of the 2004 plan year the Insurance Committee will be asked to consider various methods to further contain costs. Those alternatives may be increased co-pays for physician's visits, a co-pay for generic drugs (currently no co-pay is required), a threshold deductible for all plan members, or other alternatives as recommended by our health care consultant or our Pharmacy Benefit Manager. They will also be asked to consider alternative health care delivery systems, such as consumer driven health care programs, or a fully-insured program, if one is made available by an insurer.

Insurance Services will continue to monitor costs of the plan on a monthly basis and make recommendations on cost containment to management.

Timetable:

Program monitoring is done on a continuous basis. Insurance Committee decisions for the 2004 plan will be completed and implemented on January 1, 2004.

4. HIPAA

RECOMMENDATION 1

The City Manager's Office in conjunction with Human Resources Management should evaluate and document the benefits of opting out of Title I of HIPAA

Management Plan of Action:

In 1998 when the City's self-insured plan was developed, the consultants hired to assist in the development were apparently unaware of a municipality's ability to opt out of the provisions of Title I of HIPAA. The plan was initially developed to mirror the tenants of the existing fully insured plan which met all the HIPAA requirements.

Following discussions with the Audit Department a review was conducted of both the provisions of Title I and other Nevada municipal self-insured programs.

The City's plan, as a non-federal governmental plan, is legally entitled to apply for, and receive exemption from six provisions of Title I of HIPAA. The provisions are:

1. Limitations on preexisting condition exclusion periods. Were we to opt out of this provision, the City would not have to provide coverage to new employees or their dependents for expenses relating to pre-existing conditions for up to 18 months after they were eligible for insurance coverage, even if they had prior continuous coverage by another plan.
2. Special enrollment periods. Were we to opt out of this provision, the City would not be required to provide coverage to dependents that lose their coverage due to qualifying events such as death, termination of employment, or divorce. Those individuals would be forced to wait until annual open enrollment to be added to the plan. We would also be allowed to require new dependents such as newborns, newly adopted children or newly acquired spouses wait until open enrollment to be added to the plan.
3. Prohibition against discrimination based on an individual's health status. Were the City to opt out of this provision, we would be allowed to provide health insurance only to those individuals who met certain "wellness underwriting criteria." Those individuals with histories of illness such as cancer, heart disease, lung disease, genetic predisposition to illness, etc., could be denied coverage, or charged more based on their health history.
4. Standards relating to benefits for newborns and mothers. Were the City to opt out of this provision, we would not be required to provide 48 hours of hospital care to women and newborns following childbirth.
5. Parity in the application of certain limits to mental health benefits. Were we to opt of this provision, the City would be allowed to place limits on the amount of coverage provided for a mental illness that are less favorable than those placed on medical and surgical illnesses. For example, we could have a $1 million lifetime limit on medical/surgical benefits, but a $100,000 or $150,000 lifetime limit on mental health benefits.

6. Required coverage for reconstructive surgery following mastectomy. Were the City to opt out of this provision, we would not be required to provide such reconstructive surgery for our employees and dependents who had undergone mastectomies.

The Center for Medicare and Medicaid Services posts those municipalities who have chosen to opt out of various HIPAA provisions. In Nevada, the City of Reno, Sparks and Washoe County opt out of provision 5. The state of Nevada opts out of provision 3, and Clark County opts out of provisions 1, 2 and 3.

The ability to opt out of these various provisions has been discussed with the Director of Human Resources, and a decision made not to pursue exemption. The rationale is as follows:

City employees have enjoyed the protections afforded by the various HIPAA provisions since their inception. They were provided when we were fully insured, and were continued when we became self-insured. Exemption from any or all of the provisions would represent a disadvantage to our affected employees and could represent higher costs to them.

As the vast majority of health insurance programs provide the protection afforded under HIPAA, applicants for City positions would perceive our failure to do so as a flaw in our system. Indeed, failure to provide coverage for a newborn or a dependent with a pre-existing condition could negatively affect our ability to recruit and hire qualified individuals.

There was little consistency in the various governmental entities' election to request exemption. Reno, Sparks and the Washoe County School District chose to request exemption from the mental health parity provision. When their broker was questioned, the response was that this was perceived to be a "cost issue". However, in reviewing our City Health Insurance Plan expenses, we learned that compliance with the Mental Health Parity Act has not resulted in additional costs to the Plan. Chemical and substance abuse are the areas that would be of most concern, and HIPAA specifically exempts them from the provision. Under HIPAA, we are allowed to limit the number of mental health visits, as well as have co-pays and co-insurances that reflect the cost of the medical service provided. Monies spent on mental health may be applied to the lifetime limit imposed by the Plan. Therefore, we believe there would be minimal, if any, savings from obtaining an exemption from the Mental Health Parity Act.

There may be savings available from the procurement of an exemption from the other provisions outlined above. The Clark County Benefits Administrator cited "cost considerations" when questioned regarding the three provisions from which they opt out. Again, the ability to pick and choose those individuals we cover, to not provide care for a newborn, or refuse reconstructive surgery after a mastectomy would, indeed, save the Plan money. It would also label the City's Plan a lesser Plan than

the most draconian HMO plan available, and would, undoubtedly, affect our ability to attract and retain employees.

Timetable: The analysis is complete.

5. MONITORING OF PERFORMANCE

RECOMMENDATION 1
Insurance Services should require the TPA to pay 15% of the quarterly administrative fees for periods of noncompliance with contractual standards.

Management Plan of Action:

On two occasions the City of Las Vegas received penalty payments for noncompliance from our former Third Party Administrator (TPA). The idea behind the penalty clause is to identify problem areas and have the problem corrected. After the second penalty payment, the City reviewed the factors associated with the noncompliance and determined that the former TPA was not correcting the problems that had been identified. Therefore, it was decided that termination of the contract was the proper course of action.

Timetable: N/A. TPA terminated 10/31/02.

RECOMMENDATION 2

Insurance Services should implement measures to monitor the performance standards specified in the TPA contract

Management Plan of Action:

Insurance Services does monitor reports generated by the TPA on a monthly basis. When problems are identified, corrective actions are discussed with the TPA. If the TPA has not met the performance criteria outlined in the contract, then the penalties are assessed. A bill for the amount of assessed penalties will be sent immediately at the end of the performance period. If the TPA continues to not meet its' contractual obligations, then the City will take appropriate action to replace the TPA.

As the only methodology available to us to monitor day-to-day operations of the TPA is via the reports provided by the TPA, once every two years, an external audit is performed to ensure the TPA is adhering to the performance standards outlined in the contract. Should noncompliance be identified at that time, the TPA will be billed immediately for the period(s) of noncompliance.

Timetable: Ongoing

RECOMMENDATION 3

Insurance Services should require that the TPA make penalty payments in a timely manner once non-compliance has been identified.

Management Plan of Action:

The previous TPA was required to make two penalty payments, and on a third occasion, provided services for free for which they were they were eligible for payment under the contract, in lieu of a penalty payment. The services, (provision of over 4,000 cards, at a cost of $1 each and the contribution of $5,000 towards an actuarial valuation), together were valued at more than the assessed penalty. Again, it should be noted that the penalty is simply a vehicle to ensure service. We don't want the penalty money; we want claims paid in a correct timely manner.

The new TPA contract provides for performance standards beginning April 1, 2003. Reports will be monitored on a monthly basis, and if performance standards are not met, the City will require payment of the penalties within thirty (30) days of issuance of the letter identifying the amount of the penalty and the period of noncompliance with performance standards. If payment is not received within that thirty day period, the City will withhold the amount of the penalty from the Administration Fee due the TPA at the next billing cycle.

Timetable: Ongoing.

6. DATA ANALYSIS

RECOMMENDATION 1

Insurance Services should regularly perform reconciliations and data analysis with the TPA to ensure the accuracy and completeness of member information and claims information.

Management Plan of Action:

Insurance Services has requested the HR Information Systems Coordinator to develop an Oracle report on employee and dependent eligibility. This report will be supplied in electronic form to the Third Party Administrator on a quarterly basis. The Third Party Administrator has been asked to develop a computer report that will compare their data to the data supplied quarterly by the City, and note any discrepancies. Insurance Services will then investigate those discrepancies.

It should be noted that in a recent audit of our previous Third Party Administrator, the auditor was specifically requested to audit for payment of claims on behalf of ineligible individuals. The auditor did not find a single instance of such payment.

Timetable:

Completion of the HR Oracle report and the Third Party Administrator's comparison report is anticipated by July 1, 2003.

7. REVIEW OF TPA CHECK REGISTER

RECOMMENDATION 1

Insurance Services should work with the claims auditor to develop ways to monitor and review claim information.

Management Plan of Action:

A letter has been written to the auditor who performed the claims audit on our group health plan and our pharmacy benefit plan, asking for his recommendations for ways to monitor claims payments without increasing our liability for violation if HIPAA Privacy Regulations. His recommendations will be evaluated and implemented, if feasible.

Timetable: Insurance Services anticipates completion by July 1, 2003.

RECOMMENDATION 2

Insurance Services should request more detailed check registers from the TPA to allow for a more detailed analysis of the transactions.

Management Plan of Action:

Due to the constraints on information imposed by the HIPAA Privacy Regulations, Insurance Services disagrees with this recommendation. Indeed, we have taken steps to reduce the amount of information provided to us on individual claim payments, to reduce the risk of inadvertently revealing private health care information to inappropriate recipients. As stated above, we will evaluate the recommendations of the auditor to determine if more thorough monitoring methods may be developed without increasing the risk of violating the provisions of HIPAA.

Timetable: N/A

RECOMMENDATION 3

Insurance Services should increase its monitoring and scrutiny of the weekly claims payment check register by establishing and performing more detailed review procedures.

Management Plan of Action:

A letter has been written to the auditor who performed the claims audit on our group health plan and our pharmacy benefit plan, asking for his recommendations for ways to monitor claims payments without increasing our liability for violation if HIPAA Privacy Regulations. His recommendations will be evaluated and implemented, if feasible.

Timetable: Insurance Services anticipates completion by July 1, 2003.

8. EMPLOYEE BENEFIT PLAN DOCUMENT AVAILABILITY

RECOMMENDATION 1

Insurance Services should develop a process to inform employees annually of Plan Document changes and availability.

Management Plan of Action:

Insurance Services sends a memo to each employee covered by the City Health Insurance Plan prior to the onset of each new plan year. That has been done since the inception of the self-insured plan in 1998. In addition, if changes are made, such as changes to pharmaceutical co-pays, or benefits are added, such as the addition of age and gender-related wellness benefits, a special memo is sent to each employee covered by the Plan. This information is also provided at the annual open enrollments meeting, via All Exchange User e-mails, and printed in the City Team. An overview of the medical, dental, vision and drug benefit program is available on the City's Intranet site, as well, and is updated as changes occur. We believe this recommendation has already been fulfilled.

Timetable: N/A

RECOMMENDATION 2

Insurance Services should make the most recent version of the Plan Document available to employees in a variety of ways, such as via the Internet, the Intranet, and available for pickup at Insurance Services.

Management Plan of Action:

The Department of Labor requires that a complete Plan document be provided to a new employee at time of eligibility and no less than once every five years thereafter. They also require that participants be provided with Plan amendments no later than 270 days after an amendment takes place. (Only amendments must be sent. The entire Plan is not required.) The City has exceeded those requirements. A copy of the Plan document, in its entirety, was sent to all City Health Insurance participants in January of 2003. In addition, employees have always had the ability to obtain a complete Plan document by requesting a copy from Insurance Services.

The Plan document is a very large document - 86 pages long, doubled-sided. Since the Plan overview was available on the Intranet, and since employees could simply request a copy of the complete document from Insurance Services, it was not posted in its entirety. A request has been made to the HR Information Systems Coordinator to facilitate such a posting.

Timetable: July 1, 2003

9. PAYMENT PROCESSING

RECOMMENDATION 1

Insurance Services should process all COBRA and retiree insurance payments in accordance with the Municipal Code and the City's Cash Handling Policy.

Management Plan of Action:

Meeting the Finance and Business Services Cash Handling Policy is problematic, as typically, checks arrive sporadically, and are in small amounts. The Office Specialist II assigned to handle collections stores the checks in a lock box inside of a locked cabinet until she has three or four checks and then fills out the paperwork required for deposit and enters the information into the Atlas system. This process requires taking time from customer service activities, and is certainly more efficient when done for several checks as for just one. However, Insurance Services has requested a meeting with Mary McQuoid of Finance, to determine if a methodology can be developed that will satisfy both Finance and Insurance Services' goals.

Timetable: Completion is anticipated by April 30, 2003.

10. DEFERRED COMPENSATION

RECOMMENDATION 1

Insurance Services should consider, evaluate and document an RFP for deferred compensation plan managers to make an educated decision of which plan managers the best value and lowest fees for City employees and decide whether to add, remove, or retain the current plan administrators

Management Plan of Action:

Deferred compensation plans were offered to Municipalities in 1979. Hartford Life was the first to offer such a plan to the City of Las Vegas in 1983. They were the sole provider of deferred compensation plans until 1993. At that time, ICMA Retirement Corporation was added as an option for the Management employees of the City. ICMA was selected since they were originally established for Management employees of States and Municipalities, and assets from other Municipalities were easily transferred to the City ICMA plan.

The City of Las Vegas has an Investment Committee that reviews, evaluates, and considers changes to the various deferred compensation plan. Over the past five years, the Committee has reviewed and authorized plan changes which included such items as a reduction of the Mortality, Expense and Risk fees to 0.0% on the Hartford plan, elimination of the General Account Market Value Adjustment from the plan, and interest crediting to provide a portfolio interest rate. In addition, fees and performance were evaluated via an external audit performed by Mercer, Inc.

The Committee has also reviewed proposals from Prudential, Fidelity Securities and John Hancock. In each case, these companies would only match the 0.0% fees if their fund totally replaced both the Hartford and ICMA. Our employees would then be forced to move their monies into the new fund, regardless of their desire to do so.

In addition, should a replacement plan be implemented, all assets in the current Hartford and ICMA accounts would need to be liquidated. Since the market has been in a downturn for quite some time, employees would take unnecessary losses on their assets. Since fund accounts are never identical, investment choices could be minimized to current participants. The Committee decided that total replacement was not a viable option.

Timetable: N/A

RECOMMENDATION 2

Insurance Services should compare deferred compensation plan fees offered by the current plan administrators to those of investment management companies.

Management Plan of Action:

Investment management companies were evaluated against the City plans in the external audit completed by Mercer, Inc. The result was that fees were "not out of line" with other 457 providers, including investment management companies. Additionally, the City of Las Vegas negotiated fee reductions of the Mortality, Expense and Risk fees to 0.0% on the Hartford Plan. While ICMA charges an annual administration fee, the City of Las Vegas participates in the ICMA *EZLink program,* and participants' accounts are credited, on a quarterly basis, with a sum equal to ¼ of 5 basis points of the monthly average balance of the plan assets in the prior quarter. Effectively this offsets the annual fee charged to ICMA participants.

Again, should a replacement plan be implemented, all assets in the current Hartford and ICMA accounts would need to be liquidated. Since the market has been in a downturn for quite some time, employees would take unnecessary losses on their assets. Since fund accounts are never identical, investment choices could be minimized to current participants.

Timetable: N/A

RECOMMENDATION 3

Insurance Services should evaluate companies offering no-load funds as an option for deferred compensation.

Management Plan of Action

Both the Hartford and ICMA **are** no-load funds. This means that when a participant contributes $100 to a Hartford or ICMA account, the entire amount goes into the account. On the other hand, load funds will deduct commissions prior to funds being allocated to the account. For example, an account with a 10% load would take $10 commission from the $100 investment, and apply the remaining $90 to the account. However, any fund manager may charge management/asset fees, 12b-1 fees, or investment fund fees. They may charge more than one type of fee, but in any case, fees are charged. This is how the investment company makes their money. As stated earlier, management fees with the Hartford are 0.0%, and ICMA fees are on a sliding scale. Once there are enough assets in the ICMA account, the management fees will drop to 0.0% and the annual participant fee will also be eliminated.

11. MEDICAL AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

RECOMMENDATION 1

Insurance Services should develop a contract with its current 125 plan administrator to ensure the agreed upon terms are clearly defined.

Management Plan of Action:

Insurance Services agrees. BenefitElect has been contacted and they are working with Insurance Services to develop a contract acceptable to both parties. It will then be reviewed by the Legal Department and finalized.

Timetable: Completion is anticipated by July 1, 2003.

RECOMMENDATION 2 & 3

Insurance Services should consider, evaluate and document an RFP for 125 plan administrators. Insurance Services should review 125 plans and determine how it can best provide this benefit to employees at the lowest cost.

Management Plan of Action:

Insurance Services has reviewed the current administrators and determined that a change is not appropriate or necessary at this time. City of Las Vegas employees are extremely satisfied with the services provided by BenefitElect. Reimbursements are very prompt, usually within less than a week of submission of receipts. The fees ($5.00 per month) are in line with other such providers, and have not been raised in six years. Clark County was contacted, and inquiry made regarding their Flex 125 program administrators. Their Benefits Administrator indicated that they had gone out for bid last year, selected the lowest bidder, and were very unhappy with the service. While the fee is $3 per month, it was set with the understanding that the provider, who also sells other insurance products, would have free access to the employees for marketing purposes. The employees have been unhappy with this arrangement.

Insurance Services believes we are getting excellent service at an acceptable price and we do not agree that an RFP at this time is appropriate.

Timetable: N/A

RECOMMENDATION 4

Insurance Services should regularly promote the benefits of a 125 plan.

Management Plan of Action:

All employees are eligible for pre-tax dependent premiums under Section 125, and the City has chosen to have a negative enrollment system. All employees who sign up for pre-tax dependent premiums remain in that status until, at an open enrollment, they elect to opt out. This covers the vast majority of employees. The other benefits available under Section 125 are unreimbursed medical and child care. The City's group health plan is very comprehensive, and very generous. There are few out of pocket expenses.
In addition, many employees are reluctant to utilize the unreimbursed medical feature, due to the IRS requirement of "use it or lose it". Typically, employees only enroll when they know they are going to have a surgery such as lasix eye surgery or gastric bypass (items not covered by the plan). Annually, about 100 employees take advantage of this feature.

The other provision, child care reimbursement, is also not well-used. The average age of City employees is between 45 – 50. Child care is not a concern of the majority of our employees (as demonstrated not only by our employee surveys, but by the very poor response of City employees to the child care offered through Children's Choice). Child care, too, has a use it or lose it provision, and the amount deducted from an individual's paycheck is not able to be adapted when the parent's situation changes. This makes this provision less attractive.

Insurance Services annually sponsors a minimum of 50 meetings during open enrollment. A primary focus of these meetings is the Flex Plan. At the same time, a memo is sent to all employees, articles are written in the City Team, and an All-Exchange Users e-mail is sent. In addition, the 125 Plan is explained at the monthly New Employee Benefit Orientation meetings. We cannot force employees to utilize benefits in which they have no interest. Insurance Services believes the recommendation has been met.

Timetable: N/A

12. LIFE INSURANCE

RECOMMENDATION 1

Insurance Services should proactively monitor programs offered by vendors and keep employees informed when delays or problems occur.

Management Plan of Action:

Insurance Services continuously works with vendors and employees to correct problems associated with our voluntary products. It should be noted that Insurance Services is limited in its ability to correct these problems since we have no specific control over the broker or underwriter of insurance products. Pressure can be placed on the vendor to correct problems and delays but only to the degree of the threat of cancellation of the product.

Timetable: On-going

RECOMMENDATION 2

Insurance Services should contact the supplemental insurance carrier to determine when the supplemental insurance policies are to be distributed.

Management Plan of Action:

Insurance Services has contacted the supplemental insurance provider on numerous occasions in an attempt to encourage distribution of the insurance policies. However, since the supplemental policy is developed for members of the Public Employees Retirement System, we have no direct control over their actions. In addition, the broker for the supplemental life insurance plan attends the monthly new employee orientation sponsored by Insurance Services. At that time, further discussions are held concerning the distribution of the supplemental insurance policies.

Timetable: On-going until the issuance of the Supplemental Life Insurance policies.

13. OFFICE PROCEDURES

RECOMMENDATION 1

Inurance Services should update the current office procedures manual, make employees aware of the manual, and keep it updated as needed.

Management Plan of Action:

Insurance Services agrees. Employee Benefits personnel have been asked to complete the updates of the manual by July 1, 2003 and update no less than annually thereafter.

Timetable: Completion is anticipated by July 1, 2003.